STUDENT HEALTH RECORDS

The nursing process includes assessment, nursing diagnosis, identifying outcomes, planning, implementation and evaluation. This process can provide a comprehensive and systematic method of documentation of student health services.

Documentation

Documentation "is the written record of interactions between and among school health professionals, students and their families, other members of the school team and community health care providers". It also includes, the administration of screenings, procedures, treatments, and student and family education and the results or students' response to them.

The primary objectives of documentation in school nursing practice are:

Promotion of high-quality student health services
Advancement of efficient and effective school health services programs
Creation of a legal record of nursing services provided to students.[11]

The health record is a communication tool and should include within the Cumulative Health Record all information pertaining to the student's health (i.e. Immunization Record, Preventive Health Exams, Vision Exams, all screening outcomes, etc.) including the Individual Health Plan (IHP) and any Emergency Action Plan (EAP).

Each district should have clear policies and procedures that address the types of records, maintenance and protection of those school health records. Please refer to the Records Retention Schedule in the Appendix as for how long health records should be kept.